

<b>Case Number:</b>	CM14-0211332		
<b>Date Assigned:</b>	12/23/2014	<b>Date of Injury:</b>	03/19/2008
<b>Decision Date:</b>	02/13/2015	<b>UR Denial Date:</b>	11/14/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/15/2014

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Family Practice and is licensed to practice in Ohio. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a 31-year-old female with a date of injury of August 19, 2008. She injured her low back, right knee, right hip, and right ankle after falling while lifting heavy bags at work. She complains of right shoulder pain, right knee pain, low back pain, and right ankle pain. It appears she has had chiropractic care that the records do not substantiate that she has had physical therapy or egg puncture. Physical exam reveals tenderness to palpation of the lumbar paravertebral muscles with diminished lumbar range of motion. The straight leg raise test on the right side is positive for radicular pain. The right shoulder is tender with diminished range of motion and positive impingement signs. The right ankle is tender with diminished range of motion. The right knee is tender with diminished range of motion and a positive McMurray sign. She has been treated with topical analgesics. The diagnoses include thoracic sprain, myalgia/myositis, lumbar sprain, ankle sprain, hip/thigh sprain, and depression and anxiety. At issue is request for an MRI of the lumbar spine, LINT therapy, physical therapy, a functional capacity evaluation, voltage actuated sensory nerve conduction testing, acupuncture, and chiropractic care. It appears that the MRI scan was completed and that revealed a diffuse disc bulge with annular tear at L4-L5 with evidence of effaced nerve roots bilaterally at L4. The MRI scan was not certified the basis that the injured worker did not have radicular symptoms. The physical therapy, acupuncture and chiropractic care was not certified in the basis that it was done previously without evidence that a home exercise program could not be continued. The LINT and voltage actuated sensory nerve conduction testing was not certified based on lack of medical necessity per MTUS guidelines.

### IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

**MRI of the lumbar spine:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, MRI.

**Decision rationale:** Per the Official Disability Guidelines, MRI of the lumbar spine is indicated for uncomplicated low back pain, with radiculopathy, after at least 1 month conservative therapy, sooner if severe or progressive neurologic deficit. In this instance, the injured worker does have uncomplicated low back pain with evidence of radiculopathy as shown by a positive straight leg raise test. Therefore, MRI of the lumbar spine is medically necessary.

**LINT once a week for six weeks for the low back:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Hyperstimulation analgesia.

**Decision rationale:** Hyperstimulation analgesia (LINT) is not recommended until there are higher quality studies. Initial results are promising, but only from two low quality studies sponsored by the manufacturer (Nervomatrix Ltd., Netanya, Israel). Localized manual high-intensity neurostimulation devices are applied to small surface areas to stimulate peripheral nerve endings (A fibers), thus causing the release of endogenous endorphins. This procedure, usually described as hyperstimulation analgesia, has been investigated in several controlled studies. However, such treatments are time consuming and cumbersome, and require previous knowledge of the localization of peripheral nerve endings responsible for LBP or manual impedance mapping of the back, and these limitations prevent their extensive utilization. The new device is capable of automatically measuring skin impedance in a selected body area and, immediately afterwards, of stimulating multiple points that are targeted according to differentiation in their electrical properties and proprietary image processing algorithms with high intensity yet nonpainful electrical stimulation. The therapeutic neurostimulation pulse modulation of dense electrical pulses is applied locally to specific Active Trigger Points (ATPs) which are locations of nerve ending associated with pain, providing effective pain relief by stimulating the release of endorphins, the body's natural pain killers. The gate control theory of pain describes the modulation of sensory nerve impulses by inhibitory mechanisms in the central nervous system. One of the oldest methods of pain relief is generalized hyperstimulation analgesia produced by stimulating myofascial trigger points by dry needling, acupuncture, intense cold, intense heat, or chemical irritation of the skin. The moderate-to-intense sensory input of hyperstimulation analgesia is applied to sites over or sometimes distant from, the pain. A brief painful stimulus

may relieve chronic pain for long periods, sometimes permanently. The new device takes advantage of these same principles. Hyperstimulation analgesia with localized, intense, low-rate electrical pulses applied to painful active myofascial trigger points was found to be effective in 95% patients with chronic nonspecific low back pain, in a clinical validation study. Because this procedure is not recommended, LINT once a week for six weeks for the low back is not medically necessary per the referenced guidelines.

**Physical therapy once a week for six weeks for the low back:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Physical Therapy.

**Decision rationale:** Per the Official Disability Guidelines, 10 physical therapy visits over 8 weeks are allowed for intervertebral disc disorders without myelopathy. In this instance, no evidence of prior physical therapy can be found in the submitted medical record. Therefore, the request for physical therapy once a week for six weeks for the low back is medically necessary.

**Functional capacity evaluation:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Functional restoration programs. Decision based on Non-MTUS Citation Official Disability Guidelines, Fitness for Duty

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Fitness for duty, Functional Capacity Evaluation.

**Decision rationale:** The ODG Guidelines state the following for performing an FCE: Recommended prior to admission to a Work Hardening (WH) Program, with preference for assessments tailored to a specific task or job. If a worker is actively participating in determining the suitability of a particular job, the FCE is more likely to be successful. A FCE is not as effective when the referral is less collaborative and more directive. It is important to provide as much detail as possible about the potential job to the assessor. Job specific FCEs are more helpful than general assessments. The report should be accessible to all the return to work participants. Consider an FCE if: 1) Case management is hampered by complex issues such as: - Prior unsuccessful RTW attempts. - Conflicting medical reporting on precautions and/or fitness for modified job. - Injuries that require detailed exploration of a worker's abilities. 2) Timing is appropriate: - Close or at MMI/all key medical reports secured. - Additional/secondary conditions clarified. Do not proceed with an FCE if - The sole purpose is to determine a worker's effort or compliance. - The worker has returned to work and an ergonomic assessment has not been arranged. In this instance, there is no indication from the medical record that the injured worker is at or near maximal medical improvement. There is no

mention of prior, unsuccessful attempts to return to the workforce. There are no mentions of conflicting precautions for her return to work. The criteria for a functional capacity evaluation are not satisfied per the submitted documentation. Therefore, this request is not medically necessary in accordance with the referenced guidelines.

**VSNCT for the low back: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper Back, Current perception threshold (CPT) testing

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper Back, Current perception threshold (CPT) testing.

**Decision rationale:** Current perception threshold testing is not recommended. There are no clinical studies demonstrating that quantitative tests of sensation improve the management and clinical outcomes of patients over standard qualitative methods of sensory testing. The American Academy of Neurology (AAN) and the American Association of Electrodiagnostic Medicine (AAEM) have both concluded that quantitative sensory threshold (QST) testing standards need to be developed and that there is as yet insufficient evidence to validate the usage of current perception threshold (CPT) testing. The Centers for [REDACTED] (CMS) conducted an independent review of 342+ published studies and reconfirmed their 2002 findings that there still exist conflicting data reports, lack of standards, and insufficient trials to validate the efficacy of any type of s-NCT device. Consequently, VSNCT for the low back is not medically necessary in accordance with the referenced guidelines.

**Acupuncture once a week for six weeks for the low back: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Acupuncture Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Definitions Page(s): 1. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Acupuncture.

**Decision rationale:** The ODG guidelines, section on Acupuncture state the following: Initial trial of 3-4 visits over 2 weeks. With evidence of objective functional improvement, total of up to 8-12 visits over 4-6 weeks. "Functional improvement" means either a clinically significant improvement in activities of daily living or a reduction in work restrictions as measured during the history and physical exam. In this instance, the requested quantity of acupuncture exceeds that which is recommended as an initial trial. Consequently, acupuncture once a week for six weeks for the low back is not medically necessary in accordance with the referenced guidelines.

**Chiropractic once a week for six weeks for the low back: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy and manipulation.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Manipulation.

**Decision rationale:** The ODG Chiropractic Guidelines state the following:

Therapeutic care - Mild:  
up to 6 visits over 2 weeks Severe: Trial of 6 visits over 2 weeks Severe: With evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks, if acute, avoid chronicity Elective/maintenance care - Not medically necessary Recurrences/flare-ups - Need to re-evaluate treatment success, if RTW achieved then 1-2 visits every 4-6 months when there is evidence of significant functional limitations on exam that are likely to respond to repeat chiropractic care. Severe may include severe sprains/strains (Grade II-III1) and/or non-progressive radiculopathy (the ODG Chiropractic Guidelines are the same for sprains and disc disorders). In this instance, it is evident that the injured worker has previously had chiropractic care as some of the progress notes are signed by a chiropractor. The quantity of visits was not provided and the outcome of treatment is not discussed in the submitted record. The injured worker has not returned to work. Therefore, chiropractic once a week for six weeks for the low back is not medically necessary in accordance with the referenced guidelines and based upon the submitted medical record.